



PHYSICIAN'S STATEMENT OF EXAMINATION

Michigan Department of State
Driver Assessment Support Section
Lansing, Michigan 48918-1601

Phone: (517) 241-6840

Fax: (517) 241-6848

INSTRUCTIONS FOR DRIVER/APPLICANT:

The Department of State has received information that you may be afflicted with a physical and/or mental condition that may prevent you from operating a motor vehicle safely. Please have your regular physician complete this statement and return it to the address above. It cannot be processed at a local branch office. Failure to have this form completed and returned may result in your license being withheld until we have received and evaluated this statement

RELEASE OF INFORMATION

(Application cannot be processed without signature)

To be completed by applicant or applicant's representative: Please Print:

Name (First, Middle, last)	Date of Birth	Driver License Number	
Street Address		Daytime Telephone	
City	State	Zip	
I hereby authorize and request that information regarding my medical condition be released to the Michigan Department of State.			
Applicant's Signature _____		Today's Date _____	

INSTRUCTIONS FOR PHYSICIAN: (Physician, your signature of certification is required on the last page.)

The Department of State is asking assistance in the determination of this patient's physical and mental condition as it may relate to their continued safe operation of a motor vehicle. Your professional medical opinion, the answers to these questions and any other pertinent information will help the Department assess this individual's ability to safely operate a motor vehicle. Information may be mailed directly to the Department at the address shown at the top of this form. PLEASE TYPE OR PRINT YOUR ANSWERS AND ATTACH EG OR EGK evaluation if applicable. Please fill out all section(s) indicated or that in your professional opinion, are pertinent to this applicant to help in our assessment.

- ☐ (Section A) NEUROLOGICAL OR NEUROMUSCULAR DISEASES (Page 2)
- ☐ (Section B) OTHER MEDICAL DISORDERS, GENERAL MEDICAL CONDITIONS (Page 3)
- ☐ (Section C) DRUGS AND ALCOHOL (Page 4)
- ☐ (Section D) PSYCHOLOGICAL EVALUATION (Page 5)
- ☒ (Section E) COMMENTS SECTION (Must Be Completed For All Applicants) (Page 6)

Do Not Write below this line

FOR DRIVER ASSESSMENT USE ONLY

- ☐ FAVORABLE _____ ☐ SET UP _____
- ☐ RESTRICTION _____
- ☐ MUST PASS _____ TEST
- ☐ UNFAVORABLE _____
- ☐ QUESTIONABLE _____
- ☐ REFER FOR REEXAMINATION ☐ REFER TO HEALTH CONSULTANT
- ☐ NEED ADDITIONAL INFORMATION _____
- ☐ MEDICAL ☐ VISION ☐ SKILLS TESTING

REVIEWED BY _____ DATE _____

SECTION A NEUROLOGICAL AND NEUROMUSCULAR DISEASES

I. Disease Causing Loss or Impairment of Consciousness or Confusion

- [] Epilepsy - Type: _____
- [] Narcolepsy
- [] Alcoholism (complete Alcohol & Drug Section on page 4)
- [] Cerebral Vascular Disease/Insufficiency (Complete Atherosclerosis/Heart Disease Section on page 3)
- [] Vasovagal Syncope _____
- [] Other (open & closed head injuries, craniotomies, etc.) Please explain: _____

Related Information:

- A. Age of patient at onset of illness: _____ Date of last seizure or attack: _____/_____/_____
- B. Frequency of seizure or attacks: _____
- (I) Has patient reported a seizure or attack within the last 6 months? Yes [] No []
- (ii) Has patient reported a seizure or attack within the last 12 months? Yes [] No []
- (iii) Did patient experience a loss or impairment of level of consciousness? Yes [] No []
- C. Current medication and dosage: Medication _____ Dosage _____
- Medication _____ Dosage _____ Medication _____ Dosage _____
- D. Is there reasonable medical certainty that the last seizure or attack resulted from a medically supervised change in medication or dosage? Yes [] No [] If yes, please explain: _____
- E. Has patient had any adverse reaction to treatment or medication? Yes [] No [] If yes, please explain: _____

II. Other Limiting or Progressive Neurological or Neuromuscular Diseases:

(Cerebral Palsy, Paraplegia, Muscular Dystrophy, Parkinsonism, Multiple Sclerosis, etc.)

- A. Specific diagnosis: _____ Age of patient at onset of illness: _____
- B. Please describe the patient's neuromuscular condition, including changes that are likely in the future: _____
- C. Current medication and dosage: Medication _____ Dosage _____
- Medication _____ Dosage _____ Medication _____ Dosage _____
- D. Is patient's disease/condition adequately controlled with medication? Yes [] No []
- E. Has patient had any adverse reaction to treatment or medication? Yes [] No []
- If yes, please explain: _____

III. Diseases Affecting Cognition:

- [] Dementia or Senility [] Poor Memory [] Other
- [] Impairment of Judgment [] Mental Retardation
- a) Specific diagnosis: _____
- b) Please describe the severity of the illness, treatment and prognosis: _____
- c) Current medication and dosage: Medication _____ Dosage _____
- d) Do you believe the patient is capable of safely operating a motor vehicle based on the current medical condition, including medications? Yes [] No [] Please explain: _____

Please address how the patient's condition impacts their driving ability in Section E.

SECTION B OTHER MEDICAL DISORDERS

I. Diabetes and other metabolic Disorders

- A. Type #1 ☐ Type #2 ☐ Age at onset: _____
- B. Insulin Injections? Yes ☐ No ☐ Strength _____ Frequency _____
- C. Patient follows diet instructions? Yes ☐ No ☐
- D. Patient is responsible in the management of the disease? Yes ☐ No ☐ Comments: _____

E. Reaction episodes - Those causing loss of impairment of level of consciousness:

Hypoglycemic Yes ☐ No ☐ Frequency _____

Hyperglycemic Yes ☐ No ☐ Frequency _____

Renal Disease Yes ☐ No ☐ BUN _____

Creatinine _____

- F. Was the episode unusual in the nature for this driver/patient? Yes ☐ No ☐ Please explain: _____

Date of last episode: _____ Symptoms:

Impairment of level of consciousness: Yes ☐ No ☐

Loss of motor skills: Yes ☐ No ☐

Loss of judgment: Yes ☐ No ☐

Difficulty recalling the episode: Yes ☐ No ☐

Please explain any yes responses: _____

- G. Patients condition stabilized? Yes ☐ No ☐

- H. Is there reasonable medical certainty that the last episode resulted from medically supervised change in medication or dosage? Yes ☐ No ☐ Please explain: _____

- I. Date of last blood glucose test: ____/____/____ Blood glucose level: _____ Frequency of test: _____

Vision problems: Yes ☐ No ☐ Please describe: _____

II. Atherosclerosis/Heart Disease

- A. Diagnosis: _____

- B. Peripheral vascular disease? Yes ☐ No ☐ Location of disease, i.e., arms, legs, etc., and extent of disability: _____

- C. Cerebral vascular disease: Yes ☐ No ☐

- D. Coronary vascular disease: Yes ☐ No ☐

Angina: Yes ☐ No ☐ Frequency _____ Date of onset ____/____/____

During Driving Yes ☐ No ☐

Dyspnea Yes ☐ No ☐

Syncope: Yes ☐ No ☐

Near Syncope or Confusion: Yes ☐ No ☐

Frequency _____

Arrhythmia Yes ☐ No ☐

Frequency _____ Type _____

Infarction: Yes ☐ No ☐

Dates: _____

Congestive Failure: Yes ☐ No ☐

Ever Yes ☐ No ☐

Pacemaker: Yes ☐ No ☐

Hypertension: Yes ☐ No ☐

Blood Pressure: _____

Heart Rate: _____

Current medication and dosage: Medication: _____ Dosage _____

Medication _____ Dosage _____ Medication _____ Dosage _____

OTHER MEDICAL DISORDERS (Con't)

F. Has patient had any adverse reaction to medication or treatment for the condition? Yes [] No []
If yes, please explain: _____

G. Has patient reached maximum recovery period? Yes [] No [] If no, expected date: ____/____/____
If yes, please explain: _____

Please Circle:

Functional Classification I II III IV Therapeutic Classification A B C D E

H. Is the above condition medically treatable? Yes [] No [] Please elaborate; _____

Please describe how this condition may affect the patient's ability to operate a motor vehicle safely? _____

III. General Medical Conditions (Not discussed in other sections)

A. Diagnosis: _____

B. Current Medication and Dosage: Medication _____ Dosage _____
Medication _____ Dosage _____ Medication _____ Dosage _____

C. Has patient had any adverse or other reaction to treatment or medication? Yes [] No []

D. Do you recommend driving restrictions? Yes [] No [] If yes, please explain; _____

SECTION C DRUGS AND ALCOHOL

A. Does the patient have any clinical evidence or do you have personal knowledge of patient's addiction to habituation to drugs, alcohol or tranquilizers? Yes [] No [] If yes, indicate drug and duration of addiction; _____

B. Has patient attended residential treatment or hospitalization for condition? Yes [] No [] If yes, indicate dates of treatment or hospitalization; _____

C. Is patient currently under therapy? Yes [] No [] If yes, where? _____
Duration and frequency of therapy; _____

D. Is there evidence of physical complications from alcohol or drug abuse? Yes [] No [] If yes, please explain: _____

E. Has patient been advised to abstain from addicted substance? Yes [] No []

F. Has patient followed your recommendations for treatment or therapy? Yes [] No []

G. Has patient been prescribed antabuse? Yes [] No []

H. Is patient's antabuse monitored? Yes [] No [] If yes, frequency of monitoring and by whom: _____

I. Has period of abstinence or control been established? Yes [] No [] If yes, please describe: _____

J. What is your professional prognosis for this patient's condition? _____

SECTION D PSYCHOLOGICAL EVALUATION

A. Diagnosis of psychiatric illness: _____

B. Approximate date of illness onset: _____

C. Which of the following symptoms are present? (Please check)

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Paranoid Ideation | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal Impulses | <input type="checkbox"/> Impairment of Judgment |
| <input type="checkbox"/> Euphoria | <input type="checkbox"/> Homicidal Impulses | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Poorly Controlled Anger | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Bizarre Behavior | <input type="checkbox"/> Delusions | |
| <input type="checkbox"/> Dementia or Senility | <input type="checkbox"/> Other _____ | |

(I). Please amplify on any of the above and describe, include approximate duration of illness, severity of illness, treatment and prognosis: _____

D. Current medication and dosage: Medication _____ Dosage _____
Medication _____ Dosage _____ Medication _____ Dosage _____

E. Has patient had any adverse reaction to medication, treatment or therapy? Yes ☐ No ☐ If yes, please explain: _____

F. Does medication(s) make patient drowsy? Yes ☐ No ☐

G. Is patient capable of operating a motor vehicle safely while taking the above prescribed medications(s)? Yes ☐ No ☐
Please explain: _____

H. Has patient been hospitalized for the disorder? Yes ☐ No ☐ If yes, Please indicate when, where and for how long: _____

Frequency of therapy: _____

I. Does patient follow your medical and psychiatric recommendations? Yes ☐ No ☐ Please elaborate: _____

J. Do you believe this patient is capable of safely operating a motor vehicle based on patients current medical condition, including medications? Yes ☐ No ☐ Please explain: _____

K. Do you recommend any driving restrictions based on medication or current medical condition of this patient?
Yes ☐ No ☐ If yes, please explain: _____

L. Other comments or recommended driving restrictions based on psychological condition of this patient: _____

SECTION E COMMENTS SECTION

General Patient Information and Medical Related Driving Recommendations:

1. How long has patient been under your treatment? _____
2. Has patient followed your medical recommendations? Yes [☐] No [☐]
3. Does patient keep medical appointments? Yes [☐] No [☐] Date of last visit: ____/____/____
4. Does patient take medication as prescribed? Yes [☐] No [☐]
5. Please explain any **no** answers to the above questions: _____

6. Was patient referred to you by another doctor? Yes [☐] No [☐] If yes, please indicate name and address of referring doctor: _____
7. Have you referred patient to another medical specialist for diagnosis or treatment? Yes [☐] No [☐] If yes, please indicate name and address of medical specialist patient was referred: _____

What were the results of this consultation? _____

8. Any adverse reactions to medication, treatment or therapy? Please explain: _____

 - a. Does medication make patient drowsy? Yes [☐] No [☐]
 - b. Is patient capable of safely operating a motor vehicle while taking the above medication(s)? Yes [☐] No [☐]
Please explain: _____

9. Has the patient ever had occupational or physical therapy for the condition in question? Yes [☐] No [☐]
10. Do you recommend that the Department request a statement of your patient's Psychological condition? Yes [☐] No [☐]
11. Do you recommend that the Department request a statement of Visual Acuity? Yes [☐] No [☐]
12. Should the Department require periodic medical evaluation to monitor changes in patient's condition that may affect driving ability? Yes [☐] No [☐] If yes, How often: _____
13. Do you recommend any driving restrictions (times, trip lengths, trip radius, etc.) Yes [☐] No [☐] If yes, please specify: _____

14. Do you recommend the Department conduct an on-the-road driving performance evaluation for this driver at this time
Yes [☐] No [☐] Periodically? Yes [☐] No [☐] How Often? _____
15. Please include any additional information you feel will help in assessing your patient's ability to safely operate a motor vehicle: _____

(Please complete all lines
Physician must sign and date)

PHYSICIAN'S CERTIFICATION

I certify that the statements contained in this statement of examination are true to the best of my knowledge and belief.

Name (Print or Type) _____ M.D or D.O Telephone No.(_____) _____

Address _____ City _____ State _____ Zip _____

Professional License No _____ Type of Practice or Medical Specialty _____

Physician's Signature: X _____ Date _____